		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020297

Facility Name: Manorcare at Rolling Meadows

Address: 425 Kirchoff Rd. (Number) Rolling Meadows (City) 60008 (Zip Code)

County: Cook

Telephone Number: (847) 397 - 2400 **Fax #** (847) 397 - 2414

IDPA ID Number: 521077856001

Date of Initial License for Current Owners: 07 / 01 / 77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, Reimb. Manager **Telephone Number:** (419) 252 - 5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06 / 01 / 99 to 05 / 31 / 00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) VP of Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

x

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,719	2,710	4,329	14,758	8
9	SNF/PED					9
10	ICF	16,622	14,980	2,711	34,313	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,341	17,690	7,040	49,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.50%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07 / 01 / 77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 47 and days of care provided 3685

Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12 / 31 / 00 Fiscal Year: 05 / 31 / 00

* All facilities other than governmental must report on the accrual basis.

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	271,482	25,023	3,083	299,588	2,197	301,785	0	301,785			1
2	Food Purchase		210,343		210,343		210,343	(200)	210,143			2
3	Housekeeping	129,300	16,571	8	145,879		145,879	0	145,879			3
4	Laundry	51,843	25,304	209	77,356		77,356	(14,855)	62,501			4
5	Heat and Other Utilities			158,282	158,282	12,552	170,834	0	170,834			5
6	Maintenance	36,151	8,037	41,237	85,425		85,425	0	85,425			6
7	Other (specify):*			1,552	1,552		1,552	0	1,552			7
8	TOTAL General Services	488,776	285,278	204,371	978,425	14,749	993,174	(15,055)	978,119			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	0	18,000			9
10	Nursing and Medical Records	2,027,652	158,043	5,333	2,191,028	16,994	2,208,022	0	2,208,022			10
10a	Therapy	176,322	8,106	79,034	263,462		263,462	0	263,462			10a
11	Activities	96,063	9,856	623	106,542	176	106,718	0	106,718			11
12	Social Services	28,523	75	18	28,616	3,836	32,452	0	32,452			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	2,328,560	176,080	103,008	2,607,648	21,006	2,628,654		2,628,654			16
	C. General Administration											
17	Administrative	82,949		272,509	355,458	(53,692)	301,766	0	301,766			17
18	Directors Fees							0				18
19	Professional Services			9,448	9,448	(5,152)	4,296	(4,296)				19
20	Dues, Fees, Subscriptions & Promotions			124,024	124,024		124,024	(18,517)	105,507			20
21	Clerical & General Office Expenses	231,123	29,454	201,654	462,231		462,231	(149,496)	312,735			21
22	Employee Benefits & Payroll Taxes			525,486	525,486	1,415	526,901	0	526,901			22
23	Inservice Training & Education			4,097	4,097		4,097	0	4,097			23
24	Travel and Seminar			6,583	6,583		6,583	0	6,583			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			89,855	89,855		89,855	0	89,855			26
27	Other (specify):*							0				27
28	TOTAL General Administration	314,072	29,454	1,233,656	1,577,182	(57,429)	1,519,753	(172,309)	1,347,444			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,131,408	490,812	1,541,035	5,163,255	(21,674)	5,141,581	(187,364)	4,954,217			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			244,236	244,236	21,674	265,910	0	265,910			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			0				(42,583)	(42,583)			32
33	Real Estate Taxes			405,080	405,080		405,080	0	405,080			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			7,976	7,976		7,976	0	7,976			35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			657,292	657,292	21,674	678,966	(42,583)	636,383			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		105,413	722	106,135		106,135	0	106,135			39
40	Barber and Beauty Shops		18,484		18,484		18,484	0	18,484			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			85,096	85,096		85,096	0	85,096			42
43	Other (specify):*		28,583		28,583		28,583	0	28,583			43
44	**TOTAL Special Cost Centers**		152,480	85,818	238,298		238,298		238,298			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,131,408	643,292	2,284,145	6,058,845	0	6,058,845	(229,947)	5,828,898			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Previe

x

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 **Report Period Beginning:** 06 / 01 / 99 **Ending:** 05 / 31 / 00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(200)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(14,855)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(42,583)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,089)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,643)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,238)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,296)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(139,526)	21		24
25	Fund Raising, Advertising and Promotional	(18,517)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (229,947)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (229,947)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS **Page 5A**

Facility Name: Manorcare at Rolling Meadows
ID# 0020297
Report Period Beginning: 06 / 01 / 99
Ending: 05 / 31 / 00

Print Other Adjustment

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(200)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	(200)	2	Line 4	(14,855)
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	(14,855)	4	Line 8	(15,055)
9	Non-Straightline Depreciation	0	0	Line 9	0
10	Interest and Other Investment Income	(42,583)	32	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	(6,089)	21	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	(2,643)	21	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	0	0	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	(1,238)	21	Line 19	(4,296)
21	Owner or Key-Man Insurance	0	0	Line 20	(18,517)
22	Special Legal Fees & Legal Retainers	(4,296)	19	Line 21	(149,496)
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	(139,526)	21	Line 23	0
25	Fund Raising, Advertising and Promotional	(18,517)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	0
29	Non-Paid Workers	0	0	Line 28	(172,309)
30	Donated Goods	0	0	Line 29	(187,364)
31	Amortization Expense	0	0	Line 30	0
32				Line 31	0
33				Line 32	(42,583)
34				Line 33	0
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	(42,583)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(229,947)

47–125

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(200)	0	0	0	0	0	0	0	0	0	0	(200)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(14,855)	0	0	0	0	0	0	0	0	0	0	(14,855)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,055)	0	0	0	0	0	0	0	0	0	0	(15,055)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,296)	0	0	0	0	0	0	0	0	0	0	(4,296)	19
20	Fees, Subscriptions & Promotions	(18,517)	0	0	0	0	0	0	0	0	0	0	(18,517)	20
21	Clerical & General Office Expenses	(149,496)	0	0	0	0	0	0	0	0	0	0	(149,496)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(172,309)	0	0	0	0	0	0	0	0	0	0	(172,309)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(187,364)	0	0	0	0	0	0	0	0	0	0	(187,364)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(42,583)	0	0	0	0	0	0	0	0	0	0	(42,583)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(42,583)	0	0	0	0	0	0	0	0	0	0	(42,583)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(229,947)	0	0	0	0	0	0	0	0	0	0	(229,947)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Manorcare at Rolling Meadows # 0920297 Report Period Beginning: 06/01/99 Ending: 05/31/00

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (SEE R.O. COST REPORT)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference:	
Schedule V	Line	Item		Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	SEE	Home Office Allocation	$ 272,588	HC & Manorcare, Inc.		100.00%	$ 272,588	$ -	1
2	V	PAGE								2
3	V	6								3
4	V									4
5	V	10a	Therapy Management	15,022	Heartland Management Services		100.00%	15,022		5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			$ 287,531				$ 287,531	$ -	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	38	39	40	41	42	43

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Previe

x

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 5 / 31 / 00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summti St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252 - 5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	100,182,693	357 Nurs. Fac.	$ 388,478	$ 221,496	272,509	$ 1,057	1
2	5	Utilities	Accumulated Cost	100,182,693	357 Nurs. Fac.	4,614,666		272,509	12,552	2
3	10	Nursing	Accumulated Cost	100,182,693	357 Nurs. Fac.	6,247,503	4,177,723	272,509	16,994	3
4	17	General & Administrative	Accumulated Cost	100,182,693	357 Nurs. Fac.	80,443,795	26,746,978	272,509	218,817	4
5	22	Employee Benefits	Accumulated Cost	100,182,693	357 Nurs. Fac.	520,233		272,509	1,415	5
6	30	Depreciation	Accumulated Cost	100,182,693	357 Nurs. Fac.	7,968,019		272,509	21,674	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 100,182,694	$ 31,146,197		$ 272,509	25

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8								Interest Income Offset			(42,583)	8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	404,397	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	404,397	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	404,397	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	683	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	405,080	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	307,871	8
	1996	315,050	9
	1997	318,892	10
	1998	375,895	11
	1999	334,836	12

R/E TAX PAYMENTS
FALL 1999 216,449
SPRING 2000 187,948

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Previe

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,900 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 155,000	1
2					2
3	TOTALS			$ 155,000	3

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	$ 1,350,315	$ 54,086		$ 54,086	$	$ 986,413	4
5				1990	765,804						5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Current Year Depreciation					132,358		132,358		699,869	9
10				1987	72,739						10
11				1988	33,303						11
12				1989	74,517						12
13				1990	157,389						13
14				1991	127,927						14
15				1992	107,998						15
16				1993	73,889						16
17				1994	71,280						17
18				1995	236,489						18
19	HVAC/DUCTWORK			1996	3,845						19
20	PLUMBING			1996	2,184						20
21	CORPORATE OVERHEAD			1996	7,272						21
22	REMODEL ARCADIA/DINING/BEDROOM			1996	95,560						22
23	PROFESSIONAL FEES			1996	1,737						23
24	CORNER GUARDS			1996	1,340						24
25	WOODEN DOORS			1996	11,077						25
26	WALLCOVERINGS			1996	5,279						26
27	ELECTRICAL/LIGHTING			1996	7,005						27
28	CARPETING			1996	3,300						28
29	REBUILD GENERATOR			1996	1,927						29
30	REPLACE SMOKE DETECTOR			1996	2,156						30
31	INSTALL HANDRAILS			1997	8,660						31
32	WALL GUARDS			1997	2,756						32
33	REPLACE CEILING TILES			1997	12,173						33
34	REMOVE & INSTALL FIRE DOORS			1997	2,012						34
35	INSTALL CLOSET DOORS			1997	10,821						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 186,444		$ 186,444	$	$ 1,686,282	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	WALLCOVERINGS			1997	4,812						9
10	DECORATING			1997	10,594						10
11	CARPETING			1997	2,343						11
12	FLOORING			1997	11,254						12
13	REPAIR ELEVATOR			1997	3,430						13
14	ROOFING			1997	1,679						14
15	REMODELING			1997	8,663						15
16	CONNECT WATER AND GAS LINES			1997	1,705						16
17	CORPORATE OVERHEAD			1997	10,515						17
18	RETIREMENTS			1987	(44,531)						18
19	RETIREMENTS			1992	(36,743)						19
20	FACILITY PLAN ALLOC,			1997	5,964						20
21	REPLACE CLOSET DOORS			1997	12,000						21
22	PROFESSIONAL FEES			1997	1,396						22
23	CEILING TILES			1997	10,349						23
24	INSTALL CIRCULATING PUMPS			1997	2,250						24
25	BOILER WORK			1997	5,613						25
26	WALLPAPER			1997	482						26
27	STORAGE SHED			1997	789						27
28	ROOF WORK			1998	53,389						28
29	DOORS/WINDOWS			1998	10,090						29
30	PLUMBING			1998	3,838						30
31	RENOVATE PT & OT ROOMS			1998	4,500						31
32	DOOR & WINDOW CASINGS			1998	4,500						32
33	GENERAL CONTRACTOR FEES			1998	4,416						33
34	INSTALL STEEL DOORS			1998	4,224						34
35	ELECTRICAL			1998	754						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	REMODELING			1997	(8,489)						9
10	PAINTING/WALLCOVERING			1998	36,239						10
11	PLUMBING			1998	13,534						11
12	ELECTRICAL			1998	10,004						12
13	DEVELOPERS			1998	11,097						13
14	FLOORING/CEILING			1998	985						14
15	HVAC			1998	37,124						15
16	DOOR/WINDOW			1998	8,160						16
17	SIGN			1998	11,862						17
18	ROOFING			1998	92,520						18
19	MASONARY			1998	1,499						19
20	CARPENTRY			1998	1,475						20
21	FINISH STUDS			1998	26,279						21
22	GENERAL CONTRACTOR FEES			1998	4,601						22
23	CONCRETE SIDEWALK			1998	1,482						23
24	FLOORING/CEILING			1999	1,340						24
25	CARPENTRY			1999	19,278						25
26	FINISH STUDS			1999	25,000						26
27	PAINTING/WALLCOVERING			1999	750						27
28	WINDOW TREATMENTS			1999	525						28
29	ROOF WORK			1999	6,098						29
30	ROOFING CONTRACT			1999	876						30
31	DRAIN/FLASH SCUPPERS/OVERFLOW			1999	1,782						31
32	ROOFING CONTRACT			1999	6,098						32
33	BUILDING IMPROVEMENTS			1999	4,554						33
34	BUILDING IMPROVEMENTS			1999	22,150						34
35	INSTALL CLOSETS			1999	2,895						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	25 EXIT SIGNS FOR BU			1999	4,810						9
10	VINYL WALLCOVERING			1999	336						10
11	WALLCOVERING			1999	226						11
12	RENOVATE NURSING STATIONS			1999	11,478						12
13	WALLCOVERING			1999	2,245						13
14	DAMPER MOTOR			1999	2,693						14
15	CHART RACK			2000	1,450						15
16	ELECTRICAL FOR A/C UNITS			2000	1,214						16
17	WALLCOVERING			2000	294						17
18	ELECTRICAL FOR A/C UNITS			2000	1,151						18
19	WORK STATIONS BOOKKEEPING & PAYROLL			2000	5,975						19
20	WORK STATIONS			2000	728						20
21	EXTERIOR LIGHTING			2000	19,956						21
22	RETIREMENTS			2000	(68,187)						22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 713,134	$ 57,792	$ 57,792	$		$ 328,789	37
38	Current Year Purchases	49,010						38
39	Fully Depreciated Assets	(181,701)						39
40	Home Office			21,674	21,674			40
41	TOTALS	$ 580,443	$ 57,792	$ 79,466	$ 21,674		$ 328,789	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	N/A			$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 244,236	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 265,910	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 21,674	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,015,071	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	N/A	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	$ 183,911	58
59			59
60			60
61		$ 183,911	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,976 Description: O2 Concentrators, Wheelchairs, Gerichars, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	913	hrs	$ 41,733		$ 45,763	$ 3,501	913	$ 90,997	1
2	Licensed Speech and Language Development Therapist	10a	503	hrs	25,232		1,485	17	503	26,734	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	5,314	hrs	109,357		8,138	4,059	5,314	121,554	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts			23,648	105,413		129,061	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Laboratory & X-Ray	39					722			722	13
14	TOTAL				$ 176,322		$ 79,756	$ 112,990	6,730	$ 369,068	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Previe

x

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05 / 31 / 00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,805	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 346,743)	767,200		3
4	Supply Inventory (priced at)	23,500		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,177		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 802,682	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	367,890		13
14	Buildings, at Historical Cost	3,460,225		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	577,692		16
17	Accumulated Depreciation (book methods)	(2,013,525)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	183,911		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,576,193	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,378,875	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 44,277	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,259		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,159		31
32	Accrued Real Estate Taxes(Sch.IX-B)	404,397		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	49,429		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 616,521	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 616,521	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,762,354	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,378,875	$	48

***(See instructions.)**

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,335,058	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,335,058	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	219,029	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 219,029	17
	B. Transfers (Itemize):		
18	**INTERDIVISION**	(1,791,733)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,791,733)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,762,354	24 *

*** This must agree with page 17, line 47.**

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,091,945	1
2	Discounts and Allowances for all Levels	(1,529,207)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,562,738	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	518,158	6
7	Oxygen	(255)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 517,903	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,238	12
13	Barber and Beauty Care	22,339	13
14	Non-Patient Meals	200	14
15	Telephone, Television and Radio	(115)	15
16	Rental of Facility Space	(90)	16
17	Sale of Drugs	107,453	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,758	19
20	Radiology and X-Ray		20
21	Other Medical Services	12	21
22	Laundry	14,855	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 154,650	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42,583	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 42,583	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,277,874	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 978,425	31
32	Health Care	2,607,648	32
33	General Administration	1,577,182	33
	B. Capital Expense		
34	Ownership	657,292	34
	C. Ancillary Expense		
35	Special Cost Centers	238,298	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,058,845	40
41	**Income before Income Taxes (line 30 minus line 40)****	219,029	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 219,029	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,740	2,992	$ 76,638	$ 25.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,232	21,214	484,198	22.82	3
4	Licensed Practical Nurses	16,253	21,148	346,773	16.40	4
5	Nurse Aides & Orderlies	71,866	95,509	1,097,606	11.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,384	6,188	156,085	25.22	7
8	Rehab/Therapy Aides	1,512	1,730	20,237	11.70	8
9	Activity Director					9
10	Activity Assistants	7,806	8,990	96,063	10.69	10
11	Social Service Workers	1,846	2,086	28,523	13.67	11
12	Dietician	26,990	29,108	271,482	9.33	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,911	2,306	36,151	15.68	17
18	Housekeepers	14,252	16,174	129,300	7.99	18
19	Laundry	5,690	6,237	51,843	8.31	19
20	Administrator	1,936	2,080	82,949	39.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,533	16,071	231,123	14.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,864	2,150	22,437	10.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,815	233,983	$ 3,131,408 *	$ 13.38	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,140	1,5	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	176	11,5	44
45	Social Service Consultant	Monthly	3,836	12,5	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 5,152		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Print Previe

0

x

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Grabarski	Administrator	0.00%	$ 82,949
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,949

B. Administrative - Other

Description	Amount
Management Fees	$ 272,509
TOTAL (agree to Schedule V, line 17, col. 3)	$ 272,509
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Legal	$ 4,296
	Social Service	3,836
	Activities	176
	Dietary	1,140
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,448

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,118
Unemployment Compensation Insurance	
FICA Taxes	261,244
Employee Health Insurance	182,851
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	28,834
Retirement Plan Expense	17,644
Other Employee Benefits	2,243
Tuition Program	3,378
Employee Vaccinations	1,147
Employee Uniforms	(5,974)
Home Office Allocation	1,415
TOTAL (agree to Schedule V, line 22, col.8)	$ 526,901

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ (357)
Advertising: Employee Recruitment	97,205
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Dues & Subscriptions	8,659
Advertising	14,896
Public Relations	3,621
Less: Public Relations Expense	(3,621)
Non-allowable advertising	(14,896)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 105,507

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 5,401
In-State Travel	953
Seminar Expense	
Auto Expense	229
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,583

* Attach copy of IMRF notifications

**See instructions.

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Previe

x

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA 5608

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 60,096 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 85,096
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? YES Indicate the amount. $ 200

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Previe